





College of Pharmacists  
of British Columbia

### APPLICATION FOR REINSTATEMENT

#### 6 YEARS OR MORE IN NON-PRACTISING OR FORMER PHARMACIST REGISTER

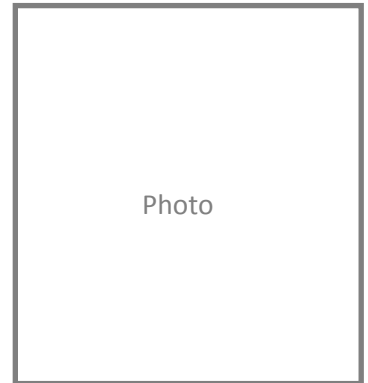
#### Notarized Identification

#### APPLICANT INFORMATION

Applicant full legal name \_\_\_\_\_  
Last name (Surname) First name Middle name

#### Required Documents

- Passport photograph, taken within one year, affixed to space provided.
- Identification
  - Present one primary and one secondary (as in table below) to the Notary for certification
  - Submit a copy of the primary identification (both sides) with this form
- Present a name change or marriage certificate if name on any document is different from legal name.



Identification presented to the Notary must be the **original** document issued by the government agency. Photocopies are acceptable only if certified by the issuing government agency to be true copies of the original.

PRIMARY		SECONDARY	
Document Type	Document Number	Document Type	Document Number
<input type="checkbox"/> Birth certificate		<input type="checkbox"/> Passport	
<input type="checkbox"/> Canadian citizenship card/certificate		<input type="checkbox"/> Valid Canadian driver's licence	
<input type="checkbox"/> Notarized affidavit (if applicable)*		<input type="checkbox"/> British Columbia identification card	
		<input type="checkbox"/> Naturalization certificate	
		<input type="checkbox"/> Canadian Forces identification	

\*If you cannot provide a birth certificate or Canadian citizenship card/certificate you must provide a notarized affidavit that states your full legal name at birth, date of birth, place of birth and the reason why you cannot provide a birth certificate.

\_\_\_\_\_ Date

\_\_\_\_\_ Applicant Signature

#### NOTARY PUBLIC CERTIFICATION

I hereby verify that the person shown in the photograph affixed on this page is the same person:

- Whose name appears as the applicant.
- Whose identity has been proven to my satisfaction through presentation of the identification indicated.
- Whose signature on this document was signed in my presence.

\_\_\_\_\_ Date

\_\_\_\_\_ Notary Signature

Notary name \_\_\_\_\_

Address \_\_\_\_\_

Tel \_\_\_\_\_

**SEAL**



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Form 11C  
Page 3 of 6

### APPLICATION FOR REINSTATEMENT

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#### Certification of Pharmacy Related Employment

#### EMPLOYEE INFORMATION

Employee name \_\_\_\_\_

Place of Work \_\_\_\_\_

Work Address \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Work Tel \_\_\_\_\_ Work Fax \_\_\_\_\_

Employee Position \_\_\_\_\_ Total hours worked \_\_\_\_\_

Start date \_\_\_\_\_ End date \_\_\_\_\_

#### EMPLOYER CERTIFICATION

I certify that the above employment information is correct.

Name \_\_\_\_\_

Position \_\_\_\_\_

Pharmacy Manager / Pharmacy Owner / Human Resources Manager

\_\_\_\_\_  
Date

\_\_\_\_\_  
Employer signature



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**Statutory Declaration (Form 5)**

*PROVINCE OF BRITISH COLUMBIA, CANADA, IN THE MATTER OF  
AN APPLICATION FOR REGISTRATION  
WITH THE COLLEGE OF PHARMACISTS OF BRITISH COLUMBIA*

I, \_\_\_\_\_, declare that (check the appropriate boxes):

- 1. I have not been convicted in Canada or elsewhere of any offence that, if committed by a person registered under the Health Professions Act and the Pharmacy Operations and Drug Scheduling Act, would constitute unprofessional conduct or conduct unbecoming of a person registered under these bylaws.
- 2. My entitlement to practise pharmacy or any other health profession has not been limited, restricted or subject to any terms, limits or conditions or disciplinary action in any jurisdiction at any time.
- 3. At the present time, no investigation, review or proceeding is taking place in any jurisdiction which could result in the suspension or cancellation of my authorization to practise pharmacy or any other health profession.
- 4. My past conduct does not demonstrate any pattern of incompetence or untrustworthiness, which would make my registration contrary to the public interest.
- 5. I am a person of good character.
- 6. I am aware of and will practice at all times in compliance with the Health Professions Act and the Pharmacy operations and Drug Scheduling Act of British Columbia, the Pharmacists Regulation and the Bylaws of the College of Pharmacists of British Columbia made pursuant to these Acts.
- 7. I shall provide the Registrar with the details of any of the following that relate to me or that occur or arise prior, during, or after my registration with the College of Pharmacists of BC:
  - a charge relating to an offence under any Act, in any jurisdiction, regulating the practice of pharmacy or any other health profession relating to the sale of drugs, or relating to any criminal offense;
  - a finding of guilt in relation to an offence under any Act, in any jurisdiction, regulating the practice of pharmacy or any other health profession relating to the sale of drugs or in relation to any criminal offense;
  - a finding of professional misconduct, incompetence or incapacity in any jurisdiction in relation to pharmacy or any other health profession;
  - a proceeding for professional misconduct, incompetence or incapacity in any jurisdiction in relation to pharmacy or any other health profession.

On a separate sheet of paper, provide details if any of the above is not true (i.e. if any of the above boxes is not checked off).  
Details to include:

- a. Criminal offence/Disciplinary action/Investigation
- b. Date when offence was committed/Applicable health profession/Applicable jurisdiction
- c. Disposition of charge including details of penalty-imposed
- d. Extenuating circumstances you wish taken into account for your application.

I declare the facts set out herein to be true.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Applicant Signature



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### Criminal Record Check Authorization

#### APPLICANT INFORMATION

Legal name \_\_\_\_\_  
*Last name (Surname) First name Middle name*

Mailing address \_\_\_\_\_  
*Street Province/State Postal Code*

\_\_\_\_\_ *Country* Contact phone \_\_\_\_\_  
*Area code*

Gender  Male  Female B.C. Driver's Licence # \_\_\_\_\_

Birthdate \_\_\_\_\_ Birthplace \_\_\_\_\_  
*YYYY-MM-DD City/town Province/State Country*

Other names used or have used (e.g. maiden name, birth name, previous married name)

1. \_\_\_\_\_  
*Surname First name Middle name*

2. \_\_\_\_\_  
*Surname First name Middle name*

3. \_\_\_\_\_  
*Surname First name Middle name*

#### FREEDOM OF INFORMATION AND PROTECTION OF PRIVACY ACT (FOIPPA)

The information requested on this form is collected under the authority of the Criminal Records Review Act and in the case of child care facilities, the Community Care and Assisted Living Act, and the regulations which govern both these acts. The information provided will be used to fulfill the requirements of the Criminal Records Review Act for the release of criminal records information and is in compliance with the FOIPPA.

#### CONSENT FOR RELEASE OF INFORMATION AND ACKNOWLEDGEMENTS

*Pursuant to the B.C. Criminal Records Review Act*

Consent information can be found at:

[http://www.bcpharmacists.org/library/3\\_Registration\\_Licensure/5144-CRC\\_Consent\\_Release\\_Information\\_Acknowledgement.pdf](http://www.bcpharmacists.org/library/3_Registration_Licensure/5144-CRC_Consent_Release_Information_Acknowledgement.pdf)

Contact the College office if you cannot access the consent information.

- I have read and understood the Consent for Release of Information and Acknowledgements above. I hereby consent to these terms as indicated by my signature below.
- I hereby authorize the College of Pharmacists of British Columbia to conduct criminal record checks on an ongoing basis at least once every five years. I understand that I may withdraw this consent for future criminal record checks.

\_\_\_\_\_ Date

\_\_\_\_\_ Applicant signature



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#### PAYMENT OPTION

Applicant Name

\_\_\_\_\_ *Last name (Surname)*

\_\_\_\_\_ *First name*

\_\_\_\_\_ *Middle name*

Bank Draft/Money order  
*(payable to College of Pharmacists of BC)*

VISA

MasterCard

Card # \_\_\_\_\_ Exp \_\_\_\_ / \_\_\_\_

Cardholder name \_\_\_\_\_

Cardholder signature \_\_\_\_\_

Application fee	399.00
Criminal Record Check fee	28.00
GST	19.95
<b>Total</b>	<b>\$446.95</b>
GST # R106953920	

**For office use ONLY**

iMIS ID: \_\_\_\_\_ Finance stamp: \_\_\_\_\_

Reg initials: \_\_\_\_\_

Date to Finance: \_\_\_\_\_